Denture or Anything But the Denture?

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About Your Speaker:

M. Nader Sharifi, D.D.S., M.S. holds a certificate in prosthodontics and a masters degree in biomaterials from Northwestern University. He received his dental education at the University of Illinois. He has presented numerous topics on implant dentistry since his graduation. His presentations on restorative dentistry and patient care have earned him recognition from esteemed study groups, societies and associations nationwide. Dr. Sharifi is a former assistant professor at Northwestern University and former on-call consultant for Nobel Biocare.

Dr. Sharifi currently maintains a full-time private practice of adult general dentistry in Chicago’s downtown loop. As a five day a week wet gloved dentist, he is interested in ensuring time saving and cost effective care. In 1996 he was named to the American Dental Associations Speakers Bureau and in 2007 Chicago Dental Society honored him with the Gordon Christenson Distinguished Lecturer Award. He has also been honored with Fellowship in the American College of Dentists and Membership in the American Academy of Restorative Dentistry.

If you would like, you may find additional information regarding other courses and additional handouts on his website at www.DrSharifi.com. If you have interest in the live denture course where CORE provides the patient send an inquiry email to LiveDentureCourse@DrSharifi.com. Please feel free to direct any other questions or comments you may have to Dr. Sharifi’s personal Email address at MNSDDSMS@aol.com.

About this handout: This handout isn’t meant to follow along slide for slide to the program today. It does somewhat, but this is more meant to be a resource in the future as you encounter these cases. This handout is written in such a manner that it can be used as a step-by-step guide when treating removable cases in your office.
Course Outline:

I. Course Synopsis
   A. What Are Overdentures
   B. Why Offer Overdentures
   C. Three Denture Steps for Success
   D. Treatment Planning Overdenture Locations and Implant Type
   E. Implant Supported Fixed Bridge for the Lower Arch
   F. Clinical Steps for Overdentures

II. Terminology – We realize that Anatomy is Very Important
   A. Retention – Influenced by Adaptation, Anatomy
   B. Stability – Influenced by Anatomy and Limitations of Existing Prosthesis
   C. Support – Influenced by Anatomy and Limitations of Existing Prosthesis

III. Definition of an Overdenture
   A. Implant Retained Overdenture – A patient removable prosthesis that receives retention and limited stability from retained roots [natural or man-made (implants)]. Support should come from the hard and soft tissue of the denture bearing mucosa, not just the natural or man-made roots.
      1. Typically fewer implants – concentrated in the anterior
   B. Implant Supported Overdenture – Patient Removable Fixed Bridge – A prosthesis that is fixed in place with attachments and locks, yet is removable by the patient for hygiene access. The natural or man-made roots provide all retention, stability and support – just like a fixed bridge. The denture bearing mucosa provides no support what so ever.
      1. Requires more implants – positioned posteriorly for A-P Spread
   C. Fixed Bridge – Hybrid Prosthesis, Fixed-Detachable, Patti Bridge, Profile Prosthesis, or All-On-Four all the same thing – a dentist removable fixed bridge. The patient cannot remove this option.
      1. Implant Position Eliminates the Need for Grafting
      2. Avoidance of Grafting reduces cost and reaches more patients
      3. Simplifies a complex treatment option increasing profitability
      4. Standardized technique replaces teeth same day they are lost
      5. High success, esthetics and hygiene access
   D. Telescopic Denture – A prosthesis that includes a partial denture framework laser welded to crowns that seat over gold copings that have been final cemented on natural abutments in the mouth. This is most typically a full arch “denture.”

IV. Why do we do overdentures?
   A. Less bone loss
   B. Improved chewing function: Bars & Balls > Magnets > F/F Dentures
   C. Improved patient satisfaction
   D. Intermediate restoration before complete edentulism
V. How Do We Make Overdentures? Make Good Dentures
   A. Three Main Steps: A well extended and well adapted denture with poor occlusion has no chance to succeed, but even a poorly extended denture with ideal centric and good occlusion can be successful.
   B. Impression Techniques
   C. Records – Centric Record Is Most Important Step
   D. Occlusal Design

VI. What Makes a Good Denture:
   A. The Big Three: Retention, Support and Stability – Stability is Key
   B. Next Two: Esthetics and Phonetics
   C. Main One: Occlusion – Excellent Occlusion overcomes poor borders.

VII. Occlusal Design – This is the difference maker.
   A. Neurocentric Flat Plane Occlusion
   B. Balanced Occlusion
   C. Lingualized Occlusion
      1. Bilateral Working and Balancing Side Contacts
      2. Cusp Form Teeth in Maxilla, Flatter Plane in Mandible
      3. Indications – Esthetics with poor bone remaining or One arch is natural, the other removable partial or complete.
      4. Controlled in Set-up on the Articulator.
         a) Maxillary incisors, cuspids, premolars and first molar mesial cusps all on same plane.
         b) Cusps then rise to shallow Curve of Spee.
         c) Mandibular posterior teeth have central groove contact to palatal cusps of the maxilla.
         d) No posterior contact of maxillary buccal cusps.
         e) Anterior open bite. If lowers are 0° – no overbite.
      5. Lingualized Options – Ivoclar OrthoLingual; Myerson Lingual Integration; Vita Physiodens; Dentsply 33°/22°; 22°/10° or 10°/0°

VIII. Delivery of Occlusion:
   A. Centric Occlusion – Again, this is the difference maker.
      1. Use Occlusal Indicator Wax to eliminate prematurities.
         a) Tap, tap, tap, and squeeze with 80% pressure.
         b) Adjust Central Groove of Lower Arch
         c) Prosthesis - equal retention with and without wax
      2. If set up is lingualized occlusion, eliminate buccal contacts.
   B. Eccentric Occlusion – Use horseshoe blue/blue articulating paper to eliminate interferences, then red/black to remove eccentric disclusions.
      1. Lingualized – blue/blue first, red/black second
         a) Blue/Blue slide side-to-side: Adjust buccal interferences on premolars on the lower and molars on the upper denture
b) Without Paper: Watch and ask patient where “hitches” occur

c) Red to Upper, slide side-to-side; Black to Upper, tap-tap-tap in centric, then adjust the upper denture to eliminate hitches.

d) Red to lower, slide side-to-side; Black to Lower, tap-tap-tap in centric, then adjust the lower denture to eliminate hitches.

e) In lingualized occlusion, eliminate all buccal contacts.

C. Centric Relation – the use of an intra-oral tracing device significantly decreases the need for occlusal adjustments – and remounts – at delivery.

1. CR Methods:

   a) Patient closure on own – Fully edentulous pts.: repeatable

   b) Tongue to top, back roof of mouth – Retracts jaw.

   c) Bilateral Manipulation – Fingers under mandible, thumbs on lower wax rim, rotate closed.

   d) Intra-oral gothic arch tracing devices – Coble Balancer. Y & M Recorder. Massad Balancer – These require a single set of baseplates and do not require a “pre-mounting” for success.

      (1) Email me for better instructions than from manufacturer.

      (2) Polyvinyl Siloxanes – Can make two bites, one to confirm

         (a) Cut Notches in Both Arches

      (3) Protrusive – Edge to edge for condylar inclination

IX. Completely Edentulous Patient Impression Techniques

A. Initial Impressions

1. Irreversible Hydrocolloid (Alginate)

   a) Canned Alginate – As good as anything else.

   b) Syringable Alginate – System 1 meant for initial imp. only

B. Final Impressions

1. Rubber Base with Green Stick Compound

   a) Break 2/3 stick of compound and drop in water bath

   b) Mold tempered stick to each area of the tray

   c) Retemper in the water bath and seat in the mouth

   d) Border Molding Upper – Can keep adding

      (1) Upper Right – pull cheek down and back

      (2) Upper Left – pull cheek down and back

      (3) Upper Anterior – smile really big, blow a kiss

      (4) Posterior – open wide, move side to side

   e) Border Molding Lower – Can keep adding

      (1) Lower Right – pull cheek up and back

      (2) Lower Left – pull cheek up and back

      (3) Lower Anterior – smile, blow a kiss

      (4) Lingual Left & Right – oppose pressure

   f) Impression Making – Trim border molding; add adhesive
(1) Wash with light body impression material
(2) Repeat all border molding steps two times

2. Polyvinyl Siloxanes with Fast-Set Bite Registration Border Mold
   a) Border Molding Sections – Bite Registration Material
      (1) Whole Right Side – Inject into the vestibule
      (2) Whole Left Side – Inject into the vestibule
      (3) Posterior – Inject onto the impression tray
   b) Impression Making – Trim border molding; add adhesive
      (1) Wash with light body material

3. Polyvinyl Siloxanes with Stock Tray Technique – Dentsply DVD
   a) Use Massad Trays from Dentsply
      (1) Heat and Trim as Needed to “Customize” to Arch
   b) Create Tissue Stops with Heavy Body Material
      (1) Support Tray Position Artificially
   c) Border Molding ENTIRE ARCH: Heavy Body Material
      (1) Inject onto the impression tray
      (2) Have Patient Hold Cheek Retractors
      (3) Trim Border Mold material and Tray as Needed
      (4) This step often needs to be repeated
   d) Impression Making: Light or Medium Bodied Materials

XV. Treatment Planning – Evaluate Overdenture cases just as complete denture cases. Use Completely Edentulous Classification as a guide (see page 2).
A. Record Collection begins with a review of history – Medical, Dental, Understand the Patient’s Chief Complaint and their Desires
   1. Prosthetic Findings (see page 3) for Anatomic Limitations
B. Extra-Oral Exam – First patient contact is outside the mouth
   1. Oral Cancer Screening and TMD Evaluation
C. Radiographic Survey
   1. Panoramic, Periapicals as needed; iCAT, Cone Beam Surveys
D. Evaluation of Hard Tissues – Positive is helpful, Negative hurts with regard to Retention, Stability and Support
E. Evaluation of Soft Tissues
F. Evaluation of Teeth
   1. Existing & Necessary Restorations; Periodontal Status
G. Evaluation of Existing Prosthesis

XVI. Bone Preservation – Ensuring time for our prostheses.
A. Primary Support Areas – Must be taken advantage of
B. Secondary Stress Bearing Areas – Must not be over stressed
   1. Maxillary:
      a) Primary – Hard Palate, Tuberosities
      b) Secondary – Residual Ridge from 1st molar to 1st molar

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2. Mandibular:
   a) Primary – Buccal Shelf (that’s it folks, gotta cover it!)
   b) Secondary – Residual Ridge from 1st molar to 1st molar

C. Primary Stabilizing Area – Lateral Throat Form in Mandible

XVII. Overdenture Attachment Selection

A. Retention – Bars > Balls, ERA, Locator > Magnets

B. Maintenance – Balls, ERA, Locator > Bars

C. Bars – Rotational or Non-Rotational
   1. Rotational Bars allow forces to be transferred to mucosa
   2. Non-Rotational Bars support the occlusal load without sharing
   3. Both bars can be made resilient, but it’s not desired with Non-Rotational bars since they don’t share load with mucosa
   4. Clips are 10 mm or more wide, need solder joints on either side so need 12 to 14 mm from implant edge to implant edge (for surgeons: 16 to 18 mm center-to-center), but the total bar length should be less than 26 mm due to strength issues

D. Implant and Root Attachments – To be considered a resilient attachment, it must provide vertical movement between 0.3 mm and 0.6 mm
   1. ERA – Resilient: Great for implants, not as great with teeth
      a) To avoid tooth supra-eruption problems, use black male only
   2. Locator – Non-Resilient: Could be a Fulcrum Point in OD
      a) Actually 0.1 mm of resiliency – very limited
   3. Implant Manufacturer Balls – Each are proprietary – ask
      a) Nobel Biocare Ball (new smaller ball) no vertical resiliency so the implants will be loaded vertically
      b) Nobel Biocare Ball (old larger ball) had blue spacer to preserve vertical resiliency & get more mucosal support
   4. OSO Balls – Non-Resilient
   5. Bredent Ball – Resilient, for use over retained natural tooth roots

E. Teeth No Attachment – Occlusal Access Filling Materials
   1. Amalgam, Composite, or Glass Ionomer – fulcrum points
   2. Gold Copings – fulcrum points
   3. Magnets – Intimate contact attachment which requires symmetry and contralateral balance; they aren’t resilient attachments.

XVIII. Overdenture Implant Abutment Position Selection – Canine areas are most common due to favorable anterior fulcrum points (except for “V” shaped arches, then use the lateral incisor spot). Combining canines & first premolars can work – otherwise avoid premolars. Second molars are also very desirable due to favorable posterior fulcrum points. Symmetry helps, unilateral hurts.

A. Mandibular Arch
1. Two Implants – can be bar clip or individual balls, Locator or ERA – should have posterior ridge height for lateral stability
   a) Bars are More Complex than ERA, Locators, but have fewer post operative complications and repairs
   b) Avoid Cantilevers from Two Implants
   c) Cantilevers can be Bars, ERAs, Locators or Anything Else
   d) Cantilevers to be avoided on Anterior and Posterior

3. Four Implants – all splinted, but clip in anterior only, cantilever ERA attachments off the back
   a) Three Points of Contact: Across the Clip, ERA, ERA
   b) Four Individual Attachments can create a fulcrum point

4. Three Implants – Triangulated Design is Non-Favorable Consider Using a Bar Across the Front of the Two Posterior Implants and behind the One Anterior Implant with Clips Parallel to Condyles.

5. Two Teeth – Locator, Magnet Copings, Non-attachment filling material, ERA with Black attachments only – avoid cantilevers

6. More Than Two Teeth – Careful about fulcrum points

B. Maxillary Arch
1. Four Implants – all splinted, but clip in anterior only, cantilever ERA attachments off the back
2. Two Implants is under designed in maxilla due to soft bone
3. Two Teeth – Locator, Magnet Copings, Non-attachment filling material, ERA with Black attachments only, but, hey, upper dentures work great – spend the money and effort in the lower
4. More Than Two Teeth – Careful about fulcrum points – select two canines and/or two second molars and make a telescopic denture!

C. Fixed Bridge Requirements – for Patti Bridge, All-On-Four, etc
1. Four implants – Bicortical stabilization in mandible and sinus wall engagement in the maxilla
2. Maximized A-P spread (anterior to posterior implant distance)
3. Minimized Cantilever
4. Longer Implants (Mandible: at least 13 mm; maxilla: 15 mm)

XIX. Overall Overdenture Attachment Conclusions
A. Non-Resilient Attachments – AVOID PREMOLAR LOCATIONS
B. Resilient Attachments can be placed anywhere, but should still provide rotation - across a fulcrum line - parallel to the condyles
C. Bars – Rotational or Non-Rotational
   A. Rotational Bars allow forces to be transferred to mucosa
D. Implant and Root Attachments –
   A. ERA – Resilient: Great for implants, not as great with teeth
B. Locator – Non-Resilient: Great for teeth, less so for implants
C. Implant Manufacturer Balls – Each are proprietary – ask
   1. Nobel Biocare Ball (new smaller ball) not resilient
   2. OSO Balls – Non-Resilient
   3. Bredent Ball – Resilient, for use over retained roots

XX. Fixed Bridge Solutions – Four implants are sufficient for a fixed bridge
   A. All-On-Four design with two posterior implants tipped to decrease the
cantilever and increase stability of the prosthesis with the elimination of a
need for grafting – helps reduce cost and creates a relative inexpensive
option compared to alternatives. It also provides immediate replacement
of teeth with high success rates, excellent esthetics & hygiene

XXI. Latest Development: Treating Patients who need to be edentulated: “Clear
Choice” type treatment – Extract remaining teeth, Place implants and
provisional bridge all in one day. Centers around the USA. You can as well.
   A. Clinical Steps for an Immediate Temporary Bridge – Print a complete
Step-By-Step clinical protocol at DrSharifi.com
   1. Plan an immediate denture to a wax trial
      a) Final impression of remaining teeth
      b) Wax records for immediate denture tooth position
      c) Wax trial if possible to confirm occlusion/speech
   2. Lab fabricate the final denture
      a) Lab Duplicates the final denture in clear acrylic as a
         surgical implant guide
      b) Lab Duplicates the final denture without teeth in clear
         acrylic as a surgical reduction guide
      c) Lab Duplicates the final denture in tooth colored teeth
         and pink acrylic base to be used as the temporary bridge
   3. Extract remaining teeth, use reduction guide to confirm ridge
      reduction, use surgical implant guide to place implants as
      planned. Connect temporary titanium cylinders to implants or
      on abutments. Use rubber dam to keep surgical site clean.
   4. Carefully relieve duplicate denture over cylinders
   5. Use BR to control vertical & centric, lute cylinders to bridge.
      Add acrylic in lab to solidify bridge, pressure pot & polish
   6. Deliver Bridge just like a denture – same occlusal schemes
   7. Plan definitive fixed bridge as noted above.
      a) Can also relieve denture and reline over healing
         abutments as a removable provisional – but that doesn’t
         help patient avoid a denture.
Clinical Fabrication of an Overdenture – Three Different Techniques

1. Impress Implants in Final Impression for Denture
2. Pick-Up Attachments Intra-Orally
3. Pick Up Attachments in Processed Base then Process Denture

1. Impress Implants In Final Denture – Best for Bar/Clip Dentures
   A. Advantages - Essentially Making a Denture, Only One Final Impression, Lab Processes Attachments, No Intra-Oral Pickup
   B. Disadvantages – Implants Complicate Difficult Lower Denture Impression, Need To Provisionalize Over Abutments
   C. Clinical Step-By-Step for Bar/Clip Denture
      a) Make a Denture – Only to Wax Trial
         (1) Duplicate Wax Up for Surgical Stent
      b) Place Implants, Relieve Denture for Osseointegration
         (1) Don’t relieve support area over the buccal shelf
      c) Expose Implants, Reline Denture Over Abutments
      d) Final Lower Denture Impression With Implants
         (1) Add 30 minutes to conventional impression time
         (2) Order implant replicas from abutment manufacture
         (3) Make an initial impression with abutments in place
         (4) Fabricate a custom tray with internal wax spacer
         (5) Seat impression copings (Nobel Biocare users: select snap-fit closed-tray impression copings)
         (6) Border mold the custom tray as usual
         (7) Remove wax spacer, trim border mold, add adhesive
         (8) Make final wash impression, seat replicas, pour
   e) Wax Records – Use Intra-Oral Tracing Device for CR
      (1) Select Teeth and Posterior Occlusal Design
   f) Wax Trial & Index Abutments - Index adds 30 minutes
      (1) Can Use Original Opposing Upper Arch Wax Trial
      (2) Make an Index of the abutments for all bar cases.
      (3) Seat Individual Index Copings using Gold Cylinders
      (4) Lute Index with GC Pattern Resin (Not Duralay)
      (5) Remove Index and Connect Abutment Replicas
      (6) Immediately Pour Index with Mounting Stone
   g) Detour to Make Framework
      (1) Lab Makes a Moulage of Wax Up – Scans model & Wax Up
         (a) Frames Must Be Tried in
         (b) Add 30 minutes for trial of framework
   h) Process Denture Over Bar (Also works for Balls, ERA, etc.)
   i) Deliver Denture Add 30’ to conventional delivery time
j) Cost is a conventional denture plus implant parts plus a lab fabricated framework that varies greatly for two or four implant cases plus two hours extra chairtime
k) May be as high as 3 or 4X conventional denture fee. The end.

2. Pick Up Attachments Under Overdenture - Retro-Fit Existing Denture – Great for Balls, ERAs, Locators

A. Advantages - Essentially Making a Denture, Single Set of Dentures Throughout, Can Retro-Fit Recent Difficult Case
B. Disadvantages – Must Pick Up Attachments Intra-Orally
C. Clinical Step-By-Step
   a) An existing denture has been processed and delivered
      (1) Duplicate Denture for Surgical Stent
   b) Place Implants, Relieve Denture for Osseointegration
      (1) Don’t relieve support area over the buccal shelf
   c) Expose Implants, Soft Line Denture Over Abutments
      (1) Use of soft liner appointments can be billed PRN
   d) Pick Up Attachments – Give Yourself an Hour
      (1) Relieve Denture Over Attachments
         (a) Both ERA & Locator use Black Males for Pick Up
         (b) Both can be picked up with or without a metal housing
      (2) Ensure Denture Seats Completely with and without the black male attachments in the mouth – this is done with GC Fit Checker or PIP Paste by checking adaptation without any attachments, then with attachments. Relieve as needed. I complete one side then the other, then confirm both together.
      (3) Use a #8 round bur to open a vent hole on the facial and lingual of each attachment location.
      (4) Locator has a white ring that helps block undercuts, but ideal to remove Black Male and Block out any undercuts under them with UltraDent Block Out Putty – make sure the retentive groove is exposed to be picked up.
      (5) Mix GC TRAD Unifast Acrylic and load disposable syringe
      (6) Seat Dentures with gentle biting pressure. Too much pressure leads to tissues being depressed, too little and the attachments won’t engage. Have the patient feel their masseters while they close without clenching.
      (7) Inject acrylic from facial and back out as attachment area fills with acrylic. Cool exothermic reaction at 3 minutes.
      (8) Remove Dentures when Acrylic is fully set at 5 minutes.
      (9) Add Acrylic Around the Attachments if Needed to Fill Voids
      (10) The Black Males must be drilled out with the appropriate
trephine drill and replaced with the colored male.
(a) Place trephine into straight handpiece and drill around center of black male. Drill to remove center.
(b) Use old curette to remove remaining rim of black male
(c) Place colored male on seating tool and snap into place.
(d) Use White male for ERA and Blue Male for Locators.
(11) Seat Denture and confirm Retention
e) Cost is a conventional denture plus implant parts plus a pick up procedure (one hour extra chairtime)
f) Easily covered in conventional fee times two (doubled)
(1) Since this is an existing denture, the fee will actually be about the conventional denture fee or two times a conventional denture fee for a new denture. The end.

3. Pick Up Attachments in Processed Base
A. Advantages – Essentially Making a Denture, Only One Final Impression, Easiest Pick Up of Attachment, Most Natural Final Impression
B. Disadvantages – Processed Base with Extra Clinical Step or labwork vs Requires Metal Substructure - Cost of Frame and Extra Clinical Step
C. Clinical Step-By-Step for ERAs, Locators
a) Make a Denture – Only to Wax Trial
(1) Duplicate Wax Up for Surgical Stent
b) Place Implants, Relieve Existing Denture for Osseointegration
(1) Don’t relieve support area over the buccal shelf
(2) Reline denture with tissue conditioner
c) Expose Implants, Reline Denture Over Healing Abutments
(1) Measure and Order appropriate implant abutments and Processing Males with metal housing
d) Final Lower Denture Impression With Implants
(1) Add 30 minutes to conventional impression time
(2) Seat abutments and torque to recommended level
(3) Snap Black ERA male and housing onto abutment (Locator)
(4) confirm custom tray fits properly over abutment height
(5) Border mold the custom tray as usual
(6) Remove wax spacer, trim border mold, add adhesive
(7) Make final wash impression right over the black males
(8) Remove impression – pouring master cast to create a stone “replica” of the black male and housing
(9) Reline provisional denture over new abutment
(10) Order processed base (or framework) with a solid collar to fit up and around black male. If you use a freework to keep lattice work throughout the arch with good tissue stops in the
central incisor, canine and second molar regions.

e) Attachment Pick Up

1) Seat black male and housing on abutments. Seat processed base (or framework) and adjust to ensure the base or the frame doesn't bind anywhere.

2) With one hand, gently hold the processed base in place (too much or too little pressure can cause difficulties). With the other hand, use GC Pattern Resin to lute the base or frame to the metal housings. Allow to set for 4 mintues.

3) Send the processed base (or framework) with the two Processing maless luted to the lab for a wax rim.

4) Have the lab grind off the black ERA male stone “replicas” to allow the frame to seat again now that the actual ERA black males have been picked up clinically. They need to ensure the frame still seats properly.

5) The lab will fabricate a wax rim directly over the baseplate.

6) Realistically you could do these last two lab steps and continue the wax records visit in your office in one visit.

f) Wax Records – Use Intra-Oral Tracing Device for CR

1) Complete wax records standardized for complete dentures

2) Select Teeth and Posterior Occlusal Design

3) The lab will mount the case and set the denture teeth

g) Wax Trial Appointment

1) Process Denture

2) The lab will need to block out INSIDE and around the ERA male housings. Otherwise they will process conventionally.

3) Black ERA males should be removed and white males seated

h) Deliver Denture

i) Cost is a conventional denture plus implant parts plus a processed base or a lab fabricated framework that varies greatly for two or four implant cases plus two hours extra chairtime

j) May be as high as 3 or 4X conventional denture fee. The end.

XII. Bottom Line – Overdentures Gotta Have Movement

A. If No Movement, Then it’s a Patient Removable Fixed Bridge

XI. Fixed Bridge, All-On-Four, Patti Bridge, Profile Prosthesis

XII. Immediate Denture Bridge, ClearChoice Treatment, Diem, Teeth In A Day

XIII. Clinical Steps – All Techniques and Options Require “Making A Denture”

A. Three Key Steps to Making Dentures

1. Final Impressions

2. Records – Intra-oral Tracing Device

3. Occlusion – Even Trumps Poor Adaptation